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The comprehensive state plan which is reported was developed over an 18-month period by nine cooperating task forces and uses federal, state, and community resources. After an outline of 10 priority recommendations for the state, a general discussion of mental retardation is given which includes estimates of prevalence at city, state, and national levels. The plan for services assesses present and future specifics on prevention, diagnosis, and treatment at seven age levels from birth through adulthood and old age. Tables present levels of retardation, Maryland's five geographic areas, population projections in those five geographic areas, estimates of retarded persons by geographic regions, services provided in 1965, and agency responsibility for services. A directory of available services in each area of the state is also included. (DF)

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COMPREHENSIVE MENTAL RETARDATION PLAN

STATE OF MARYLAND

STATE BOARD OF HEALTH AND MENTAL HYGIENE

301 W. PRESTON STREET • BALTIMORE, MARYLAND 21201

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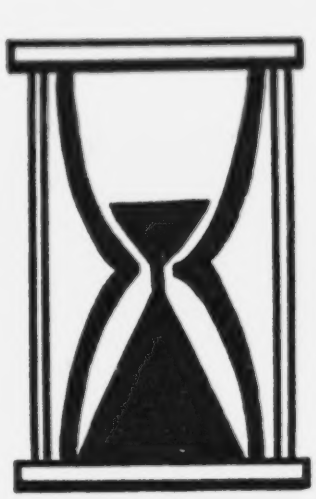
MARYLAND STATE COMPREHENSIVE

MENTAL RETARDATION PLAN

HONORABLE J. MILLARD TAWES
Governor

STATE BOARD OF HEALTH AND MENTAL HYGIENE
301 West Preston Street
Baltimore, Maryland 21201

June, 1966



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FOREWORD

Mental retardation is a complex social phenomenon which necessitates the utilization of a wide range of Federal, State, and community resources to insure that comprehensive programs designed to meet the individual needs of Maryland's retarded citizens are provided.

The Maryland Comprehensive Plan is intended to be used as a guide to State and community planners in the development of programs. It is expected that this Plan will be amended as new knowledge and changing needs dictate.

In an undertaking of this nature, it is essential that a broad representative sample of individuals and groups be involved. The further development and implementation of this Plan depend upon the continued cooperation and active participation of these interested citizens.

INTRODUCTION

The late President John F. Kennedy, convened the President's Panel on Mental Retardation on October 17, 1961, with the specific charge " . . . to undertake a comprehensive and coordinated attack on the problem of mental retardation and to prepare a National Plan to combat Mental Retardation."

A direct outgrowth of this initial activity was the submission to the President of "A Report of the President's Panel on Mental Retardation; A Proposed Program for National Action to Combat Mental Retardation." Along with the submission of this Report in October, 1963, Ten Reports of the Task Forces of the President's Panel were released for publication. In addition, the Maternal and Child Health and Mental Retardation Planning Amendments were signed into law as Public Law 88-156. This legislation provided funds, on a matching basis, to enable all states to administer planning grant programs for the following purposes:

A. Determination of needed action to combat mental retardation in the state and assessment of the resources available for this purpose.

B. Development of public awareness of the mental retardation problem and of the importance of combating it.

C. Coordination of state and local activities relating to mental retardation.

D. Planning additional activities leading to comprehensive state and local action to combat mental retardation.

E. Implementation of the plan as developed and approved.

In October, 1963, His Excellency, J. Millard Tawes, Governor of Maryland, recognizing the fact that previous planning for the needs of the mentally retarded citizens of Maryland had been neither comprehensive nor interdepartmental, established the Inter-Agency Commission on Mental Retardation in order to achieve a degree of cooperative and coordinated planning between State agencies. "Such a commission," the Governor said, ". . . should better enable us to plan a total State program for the care of the mentally retarded." At the same time the Governor designated the State Board of Health and Mental Hygiene as the single State agency responsible for comprehensive mental retardation planning in accordance with the provisions of Public Law 88-156.

The main objective of Maryland's mental retardation planning effort is to achieve a coordinated and comprehensive program to combat mental retardation. To this end the Office of Mental Retardation Planning was organized in July, 1964, under the aegis of the State Board of Health and Mental Hygiene. This planning office was assigned the responsibility for the development of a report consonant with the broad project objectives outlined in the terms and conditions received from the United States Department of Health, Education, and Welfare. In January of 1966, the Office of Mental Retardation Planning submitted to the State Board of Health and Mental Hygiene a report containing the results of its endeavors. Because of the size of this report and

the number, variety, and conflicting recommendations which it contained, the Board appointed a Planning Committee of staff members from various State agencies concerned with mental retardation to compile the information from the report into a comprehensive mental retardation plan. This was the first time State agencies were involved as a group in the planning process.

The Comprehensive Mental Retardation Plan for Maryland which follows, represents the combined efforts of the Mental Retardation Advisory Council, Task Forces, and the Committee composed of representatives of State agencies. This Plan is to be viewed as a flexible guide which will need to be reviewed, reevaluated, and changed to meet the changing needs of Maryland. The following two variables contributed to the constantly changing validity of data on mental retardation in Maryland:

1. Population changes in the State have not been consistent with population projections.
2. The involvement of State and local agencies in the planning operation has by itself stimulated some improvements in services for the mentally retarded.

For these reasons the vast amount of statistical data given in the report of the Advisory Council on Mental Retardation has been omitted from the Plan. The Planning Committee concentrated its efforts on creative programming and suggestions for effecting the Plan on a cooperative basis between agencies. Anyone desiring more background and supporting data than are herein contained should refer to the extensive tables in the report.

The Comprehensive Mental Retardation Plan represents both a culmination and a desire. It is the culmination of a cooperative process of self-analysis on the part of State agencies, professionals, and the general public. Not everyone will agree totally with the value judgments made as a result of the analytic process, but a basic consensus has been reached. More important, the presentation of this Plan represents a desire of the major State agencies concerned. Primarily it represents a guide for the retarded citizens of our State, their parents, and their friends; basic agreement has been reached as to the types of services needed to care for, train, and protect the retarded citizen. In addition, a firm commitment has been made to the even greater goal of eventual prevention of retardation through elimination of the diseases and conditions which cause it. Mental retardation is a complex rather than a simple phenomenon. It cannot be prevented, cured, or ameliorated by physicians, social workers, educators, or any other professional or lay group acting alone. A broad cooperative effort must be launched and carried through to completion. The ideas proposed in the Plan which follows may be expensive, far-reaching, difficult, and sometimes even arduous; moreover, results cannot be absolutely guaranteed. It is the belief of those presenting this Plan that the citizens of Maryland will be willing to make the necessary effort and will express this willingness in action.

Perhaps the most important desire represented by this Plan is for interagency cooperation. From the earliest stages of planning to the writing of the final draft, many agencies and many groups were involved. Total unanimity was not achieved, but it was closely approached. It has been shown once again that a sincere desire to solve a common problem can dissolve many prejudices and professional differences of opinion. For the future of the mentally retarded, there is indeed new direction to meet their needs.

PRIORITY RECOMMENDATIONS

1. The charge to the Governor's Inter-Agency Commission on Mental Retardation should be clarified and redefined. It is recommended that the Commission be strengthened by expanding it to include representatives of the State Department of Correction, the State Department of Juvenile Services, a representative of the consumer group, and a representative of the State Board of Health and Mental Hygiene which latter agency has been designated by the Governor as the State agency responsible for mental retardation planning and facilities construction. Consideration should also be given to including representation from the Legislature.

   It is further recommended that the Governor's charge to the Inter-Agency Commission include direction that these representatives meet at least every other month to perform the following functions:

   A. The Commission will advise and assist the Governor concerning mental retardation as he may require with respect to:

      1. Evaluation of the total State effort toward combating mental retardation.
      2. Coordination of the activities of State agencies responsible for providing services to the retarded.
      3. Provision of liaison among State and local governments, foundations, and private organizations concerning their activities in the field of mental retardation.
      4. Development and dissemination of information to the general public that will tend to reduce the incidence and ameliorate the effects of mental retardation.

   B. The Commission will mobilize support for mental retardation activities by meeting with and providing information for appropriate professional organizations and broadly representative groups.

   C. The Commission will make reports or recommendations to the Governor as he may request or as the Commission may deem appropriate.

2. The meetings of the Planning Committee composed of representatives from State departments having responsibility for the mentally retarded should be continued on a monthly basis. The State Board of Health and Mental Hygiene should arrange for the meetings of this committee through its executive staff and should forward reports on this committee's deliberations to the Governor's Inter-Agency Commission.

3. A systematic program of case finding should be initiated, including a mental retardation register to be maintained by an expanded statistical staff of the Department of Mental Hygiene. This case register should be separate from but coordinated with the psy-

chiatric case register. All agencies serving the mentally retarded should be required to provide data for the case register, and pertinent birth certificate data should also be included.

4. Diagnostic and evaluation services by teams of specialists trained in mental retardation should be expanded for all age levels of the mentally retarded. The team should consist of a physician, a psychologist, a social worker, and others appropriate to the age and condition of the retarded individual. Every retarded person and every person suspected of being retarded should be entitled to a thorough evaluation whenever major plans are being made for his future.

5. A comprehensive preschool program should be developed for all retarded and deprived children. This is the age at which programs of sensory development and behavioral training techniques have the greatest positive effects. An intensive preschool program could prevent many cases of mild retardation.

6. A systematic array of support services should be developed for retarded adults. These services should include: medical care, foster care, foster group homes, guardianship, small residential centers, day care programs, small group homes, counseling, and financial assistance. The purpose of these services is not to take away the freedom of retarded citizens but to provide them the help they need to live in our complex society.

7. A dual program of recruitment and development of training programs should be organized to alleviate the manpower shortage of trained workers in the service areas associated with mental retardation. Training programs for special education teachers and others working in the field of mental retardation should be supplemented and expanded at two centers: Coppin State College and the University of Maryland. These two institutions could provide sufficient training programs, if properly developed. This limitation is preferable to fragmenting these programs in many schools. Offerings should include programs leading to Associate, Bachelor's, Master's, and Doctoral degrees as well as shorter training programs for special needs. Scholarships should be made available at all degree levels.

8. Courts, law enforcement agencies, and probation officers should be made more aware of mental retardation as it affects those with whom they come in contact. Appropriate changes in State correctional and juvenile institutions need to be made to provide for the needs of the mentally retarded individuals confined there.

9. Appropriate legislative changes should be made to permit the Department of Mental Hygiene to control admission to residential programs for the retarded. The courts should no longer be permitted to commit a person directly to a residential program. Referral should be made to the operating agency for evaluation and proper programming; the agency can then decide whether residential care or another community based program would be more advantageous to the individual and the community as a whole.

10. Professional seminars and discussion groups should be sponsored through the University of Maryland and Coppin State College as well as through other colleges and hospitals, both State and private, for all who come into contact with mentally retarded persons in the course of their work. Such groups should include: social workers, employment counselors, judges, clergymen, physicians, nurses, law enforcement officers, teachers, and employees of private residential facilities.

WHAT IS MENTAL RETARDATION?

The lack of comprehensive planning, the overlapping and simultaneous omission in the provision of services, and the confusion in the public mind about mental retardation can all be traced to lack of agreement among experts as to exactly what is meant by mental retardation. In retrospect, professionals dealing with mental retardation have often seemed like the three blind men in the classic story who each described an elephant differently after touching respectively a tusk, an ear, and a tail. All three were absolutely correct; but they could not see the point of view of the others. Similarly, medical, psychiatric, psychological, and educational writings and research on mental retardation have often appeared to not even be dealing with the same condition. In fact, they were not.

Perhaps the extremes of the problem can best be seen by comparing the point of view of physicians and psychiatrists in residential facilities with the point of view of special educators in the public schools. The public schools worked with many retarded children, but mostly with the milder levels of retardation. In recent years the scope of school coverage has been extending downward to include more seriously retarded children, but these children represent an extreme minority of the total educational enterprise. The institutional psychiatrist and physician, on the contrary, began with the other end of the continuum. The most severe cases of retardation were the most certain to be admitted to the large State institutions. Almost all of these cases of retardation were caused by or associated with disease or trauma. If a mildly retarded person came to an institution, his condition usually showed other handicaps in addition to retardation.

These different points of view along with those of social workers, psychologists, jurists, and others led to a wide variety of terms, labels, and definitions for mental retardation. Idiots, imbeciles, morons, subnormal, deficient, educable, trainable, custodial, marginal, borderline, and feebleminded are among the many terms used for different categories of retarded persons in the twentieth century. Definitions of mental retardation have ranged from too narrow to extremely broad. Present space does not permit a detailed survey of this rather fascinating terminological history. The definition and categorical terms being proposed for present and future practice are of far greater importance.

The definition of mental retardation proposed by the American Association on Mental Deficiency is a suitable, standard, interdisciplinary definition of Mental Retardation. For the purposes of planning in Maryland this definition has been used in all phases of the planning operation: *Mental retardation refers to subaverage, general, intellectual functioning which originates during the developmental period and is associated with impairment in adaptive behavior.*[1]

Subaverage refers to performance which is greater than one standard deviation below the population mean of the age group involved on measures of *general intellectual functioning.*

The level of *general intellectual functioning* may be assessed by performance on one or more of the various objective tests which have been developed for that purpose. Though the upper age limit of the *development period* cannot be precisely specified, it may be regarded for practical purposes as being approximately sixteen years. This criterion is in accord with the traditional concept of mental retardation with respect to age and serves to distinguish mental retardation from other disorders of human behavior. The definition further specifies that the subaverage intellectual functioning must be reflected by impairment in *adaptive behavior*. Adaptive behavior refers primarily to the effectiveness of the individual in adapting to the natural and social demands of his environment. Impaired adaptive behavior may be reflected in: (1) maturation, (2) learning, and/or (3) social adjustment. These three aspects of adaptation are of different importance as qualifying conditions of mental retardation for different age groups.

In other words, this definition gives us a broad description of a condition which may afflict a wide variety of individuals in a wide variety of degrees. Its primary classification cannot be by cause (etiology) because it has a variety of causes, some not yet fully understood. The condition manifests itself in different ways during different periods of the life span. In young children it is often seen as a delay in growth, speech development, or general behavioral maturation. In its more serious forms it is usually associated with some additional physical involvement. In children of school age, retardation means the inability to learn; even the mildly retarded child is several years behind his age peers in "grade" placement. In adults retardation appears as an inability to conquer the problems presented by the demands of independent living in society. The retarded adult may need help with money matters; he may require personal protection; he may require total care.

The American Association on Mental Deficiency lists four levels of retardation: profound, severe, moderate, and mild. Traditionally these levels have been associated with numerical scores on tests of intelligence. More recent thinking prefers to consider these levels in terms of levels of functioning as manifested by behavior. This behavior is different at different ages. (Table I presents descriptions of this behavior in schematic form.) The *common denominator* of mental retardation is that the immediate cause of the behavioral malfunction is an intellectual deficit. The *uncommon factors* are the many different causes of retardation on one hand and its many different manifestations on the other.

It is important to note that a person may be diagnosed as retarded at one stage of life and not at another. Improvement may be due to maturation, training, surgery, medical treatment, or a combination of these factors. Although often a permanent condition, mental retardation is not *essentially* permanent or unimprovable.

Table I. LEVELS OF RETARDATION*

LEVEL	AGE 0-5	AGE 6-21	AGE 21 and Over
Profound	Gross retardation; minimal capacity for functioning in sensorimotor areas; needs nursing care.	Obvious delays in all areas of development; shows basic emotional responses; may respond to skillful training in use of legs, hands and jaws; needs close supervision.	May walk, need nursing care, have primitive speech; usually benefits from regular physical activity; incapable of self-maintenance.
Severe	Marked delay in motor development; little or no communication skill; may respond to training in elementary self-help, e.g., self-feeding.	Usually walks barring specific disability; has some understanding of speech and some response; can profit from systematic habit training.	Can conform to daily routines and repetitive activities; needs continuing direction and supervision in protective environment.
Moderate	Noticeable delays in motor development, especially in speech; responds to training in various self-help activities.	Can learn simple communication, elementary health and safety habits, and simple manual skills; does not progress in functional reading or arithmetic.	Can perform simple tasks under sheltered conditions; participates in simple recreation; travels alone in familiar places; usually incapable of self-maintenance.
Mild	Often not noticed as retarded by casual observer but is slower to walk, feed self, and talk than most children.	Can acquire practical skills and useful reading and arithmetic to a 3rd to 6th grade level with special education. Can be guided toward social conformity.	Can usually achieve social and vocational skills adequate to self-maintenance; may need occasional guidance and support when under unusual social or economic stress.

* Adapted from President's Panel on Mental Retardation 1962

INCIDENCE AND PREVALENCE OF RETARDATION

In lieu of a complete census-diagnosis of the entire American population a precise determination of the incidence and prevalence of mental retardation represents a complex statistical procedure. The implementation of comprehensive planning efforts in all fifty states will eventually refine present figures which are largely based on statistical inference. The President's Panel on Mental Retardation (1962) reported that mental retardation affects twice as many individuals as blindness, polio, cerebral palsy, and rheumatic heart disease combined. It is estimated that 3 per cent of the population or 5.4 million persons are classified retarded and are using services at any one time.[2] An additional 126,000 babies are born annually who will be regarded as mentally retarded at sometime in their lives. By 1970, it is projected that there will be 6.4 million retarded of which 400,000 will be so severely retarded that they will require constant care.

Improved and more extensive prenatal, obstetrical, and pediatric care has resulted in marked increase in the infant survival rate in the nation over the past 20 years. But such efforts have also resulted in increasing the survival rate of all infants—the premature, handicapped, or malformed—as well as the wellborn. Since mental retardation is one of the major conditions associated with such handicaps in infants, improved care has paradoxically increased the number of retarded for whom special services will be needed. Disease control, new drugs, and higher standards of living have steadily increased the life span of most Americans. While the mentally retarded as a group fall below the average life expectancy, the number of years the average retarded individual lives has been increasing proportionately with the overall average. With increased availability of health services, the life span of the retarded may continue to increase, and this will add to the numbers of the mentally retarded in the upper age levels.

At the profound, severe, and moderate levels, mental retardation strikes all socioeconomic levels of the community with about equal incidence. The mild level of retardation has a higher incidence rate among poor, culturally deprived groups. For this reason, there are large concentrations of mildly retarded individuals in urban (inner city) areas; there are also some notable pockets of retardation in some rural communities. Although the 3 per cent figure is undoubtedly valid as a national average, it gives no real clues as to the incidence or prevalence of retardation in any given area. School officials report that in Baltimore City the prevalence of mild retardation among school age children is close to 9 per cent.

The official 1960 census data were used to provide a baseline upon which to develop population projections for the years 1965-1970. These projections were provided by the State Planning Department. In order to make these data meaningful to the planning activity, the format illustrated in Table II was prepared. This table indicates the population distribution for the years 1960, 1965, 1970 by age and geographic area. This information provided the basis for developing Tables III and IV which project the population

and estimate the number of mental retardates by age, degree of retardation, and geographic area for the years 1960, 1965, and 1970. Six developmental periods relating to the following age intervals were used: 0-4, 5-19, 20-29, 30-49, 50-64, and 65+. The terms mild, moderate severe, and profound used in this report correspond to the now outmoded educational classifications of educable, trainable, and custodial; custodial being equivalent to severe and profound combined. These groupings are comparable to the American clinical classifications of moron, imbecile, and idiot. Intelligence scores associated with these levels are approximately 50-79, 20-49, 0-19; mental age equivalents at maturity are correspondingly 8-12, 3-7, 0-2 years. These data were in turn specifically related to the twenty-three counties and Baltimore City which represent the total political subdivisions of the State. These subdivisions were delineated into five geographic areas in accord with the Mental Retardation and Mental Health Construction Plans for 1965. The selection of these service areas was based on traditionally accepted divisions: Eastern Shore, Southern Maryland, Northwestern Maryland, Maryland National Capital Area, and the Baltimore Metropolitan Area. Utilization of these areas will facilitate the integration of existing and planned facilities and services with population characteristics, transportation patterns, and socioeconomic variables which are directed toward the eventual provision of a full range of specialized services required for the optimal care of our retarded citizens.

It is estimated, on the basis of population projections for 1965, that 3,445,900 residents of all ages reside within the State of Maryland. An estimated 103,382 mentally retarded individuals are included in this projection. Of this number, 89,596 are classified as mildly retarded, 10,339 moderately retarded, and 3,447 severely or profoundly retarded. These estimates are based on three per cent of the total State population.

It was possible to identify 32,676 mentally retarded individuals receiving services (Table V) although it must be noted that this figure is not necessarily free of overlapping data. The remaining 70,000 individuals not identified to date may be accounted for in one or more of the following categories:

1. Large numbers of mentally retarded persons of all ages remain unidentified as a result of inadequate services. When a full range of services becomes available, the advent of case findings on a Statewide basis will identify these individuals. Initiation of the mental retardation register will facilitate this process.
2. There are mildly retarded children in the preschool age range who are not identified until they enter kindergarten or elementary school programs.
3. In Baltimore City 47,000 children receive Public Welfare aid from the fund for families of dependent children. Many of these children are mildly retarded.
4. The Baltimore City Public School System estimates that there are between 4,000 and 5,000 four-year-olds who can be expected to experience problems in their initial school experiences and develop patterns of repeated failures throughout the regular school programs.
5. There are mildly retarded students in regular class placements in public school programs throughout the State who are experiencing poor adjustment and academic failures.
6. Many of the unskilled, chronically unemployed who marginally exist in the various counties and Baltimore City are mildly retarded.
7. There are mentally retarded children and adults cared for by families who are unwilling to seek outside assistance and who are unknown to any agency.
8. Handicapped children and adults who are mentally retarded but whose diagnosis is secondary to another medical classification. These individuals are receiving treatment.

The vast majority of the unidentified retarded fall into the mild classification.

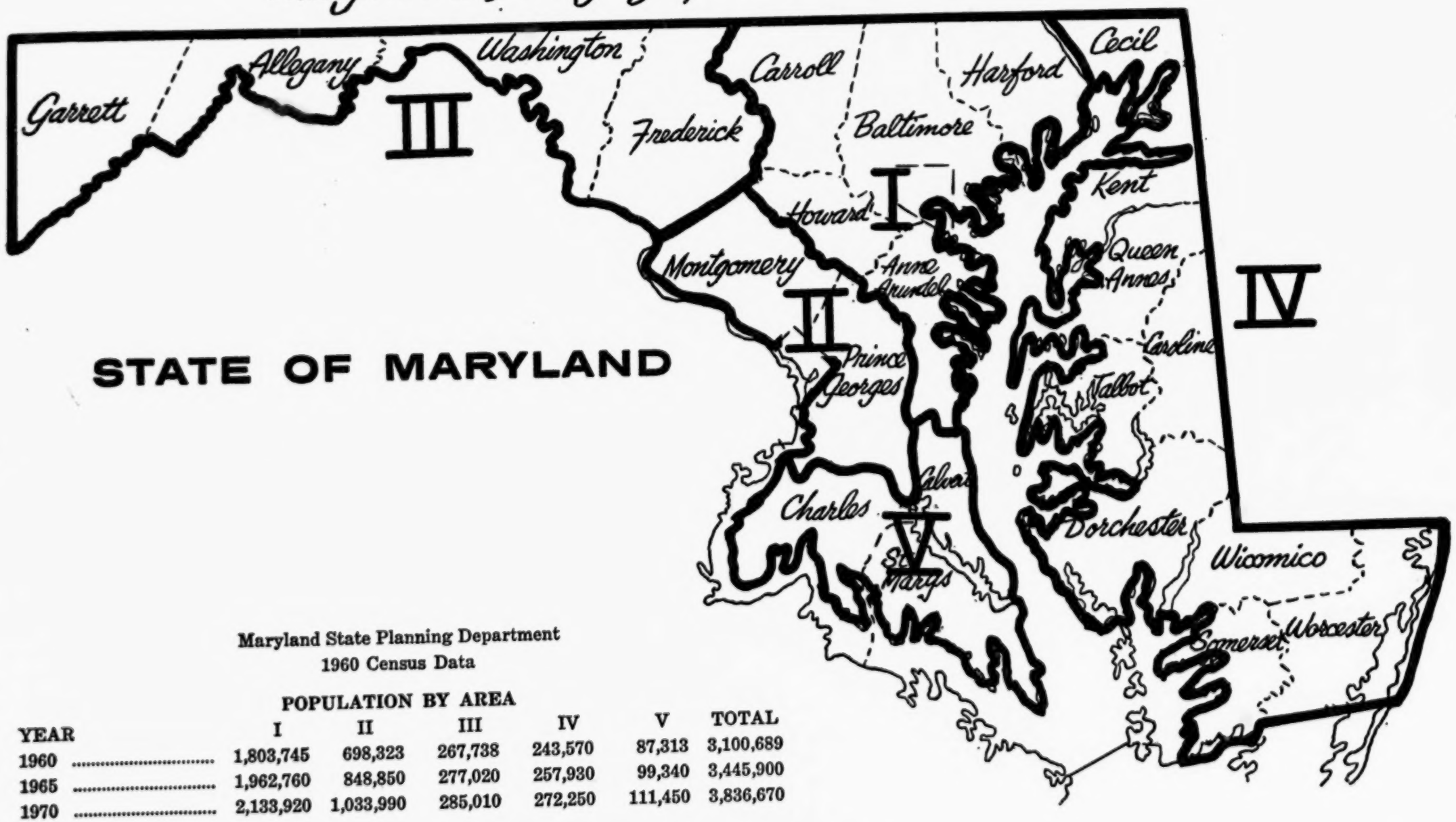
The estimates presented are not to be considered as absolute. The actual determination of the true extent of mental retardation is subject to continued examination. Investigation such as "The Rose County Study,"[3] undertaken by The Johns Hopkins School of Hygiene and Public Health may be expected to yield the definitive results necessary to conduct a Statewide epidemiological study. Preliminary analysis of data indicates a prevalence of two to more than three times the 3 per cent estimate, depending upon the age group considered. However, during the initial

stage of planning there existed no other data upon which to develop more reliable estimates. The selection of population projections developed by the State Planning Department was based on the immediate need for this information. Within the past few months, the State Department of Health has released the statistics for the year 1964.[4] The population of Maryland was estimated in this report to be 3,465,640 for the year ending July 1, 1964. This figure is greater than the estimate used for determining the incidence of mental retardation for the purposes of planning. The expressed variance reveals the complexities involved in the use of statistical data and procedures. Statistical consultation indicates a safe rule-of-thumb in allowing for a 10 per cent differential when applied to program development. Although the planning process has been able to identify 0.9 per cent of the total population as receiving services at the present time, this in no way negates the assumptions upon which the estimates were based. The test of time and continued study will provide the final determination of the extent of mental retardation. Planners are urged to use these estimates until further verification is provided. Regardless of the estimate to be used as a standard, the provision of services and facilities will not, in the near future, exceed the demand. It is strongly recommended that the presented data be used as standard estimates of the extent of mental retardation for the purposes of developing programs.

Implications for programming are found in the data for 1970, which point to the increasing demand for special education provisions for those of school age (5-19 years). Increments to a total of 33,773 are predicted for the next five years. Additionally, comprehensive services, including work experiences, should be developed to meet the needs of the retardate during the next developmental state of maturity (20-49). It is estimated that this grouping will number 44,408 during the time period stated. Approximately 24,151 retardates approaching old age (50-64+) will require a full range of work opportunities, recreational activities, and supervised medical care programs. If the increasing population demands are to be adequately met, it will be necessary to initiate planning for these services immediately and beyond the scope of those presently in development. Of the 32,676 identified retardates all but 4,244 can benefit from educational services. This finding emphasizes the increased responsibility on the part of education to increase the range of services presently offered and to encourage educators to take a more active part in all phases of program planning and development. The lack of adequate record keeping on the part of agencies involved in mental retardation programming represents one of the most significant findings of the varied activities of the Office of Mental Retardation. It is, therefore, strongly recommended that agencies make provisions for the collection of data relative to the identification, classification, and follow-up of diagnosed cases of mental retardation through the development of an interagency mental retardation register.

Table II.

Maryland's Five Geographic Areas



Maryland State Planning Department
1960 Census Data

POPULATION BY AREA

YEAR	I	II	III	IV	V	TOTAL
1960	1,803,745	698,323	267,738	243,570	87,313	3,100,689
1965	1,962,760	848,850	277,020	257,930	99,340	3,445,900
1970	2,133,920	1,033,990	285,010	272,250	111,450	3,836,670

ESTIMATED NUMBER OF MENTALLY RETARDED PERSONS BY AREA

YEAR	I	II	III	IV	V	TOTAL
1960	54,111	20,949	8,033	7,307	2,620	93,020
1965	58,884	25,465	8,311	7,741	2,983	103,384
1970	64,020	31,019	8,548	8,168	3,345	115,100

Table III. MARYLAND POPULATION DISTRIBUTION BY AGE AND GEOGRAPHIC AREA: 1960 CENSUS

		AGE GROUP						
	YEAR	0-4	5-19	20-29	30-49	50-64	65+	Total
AREA I	1960	208,772	478,236	228,351	508,758	243,288	136,340	1,803,745
	1965	210,710	578,700	248,010	501,300	270,000	154,040	1,962,760
	1970	233,200	627,660	314,930	487,620	297,400	173,160	2,133,970
AREA II	1960	90,986	205,314	85,380	210,513	73,190	32,940	698,323
	1965	98,940	265,840	113,520	233,340	96,770	40,440	848,850
	1970	120,880	313,790	167,820	256,910	125,070	49,520	1,033,990
AREA III	1960	27,220	73,561	31,127	70,709	39,018	26,103	267,738
	1965	27,510	74,710	36,700	67,780	42,360	27,960	277,020
	1970	27,790	73,390	44,370	64,420	44,990	30,050	285,010
AREA IV	1960	26,521	66,024	27,619	62,314	34,710	26,382	243,570
	1965	27,540	70,780	33,060	61,370	37,710	27,470	257,930
	1970	29,230	74,310	41,120	59,410	39,650	28,530	272,250
AREA V	1960	13,021	28,728	12,417	20,373	8,000	4,774	87,313
	1965	14,060	32,990	15,180	22,320	9,630	5,160	99,340
	1970	14,310	36,540	18,520	25,120	11,210	5,750	111,450

Maryland State Planning Department
1960 Census Data

Table IV. ESTIMATED NUMBER OF MENTALLY RETARDED PERSONS BY AGE, DEGREE OF RETARDATION, AND GEOGRAPHIC AREA: STATE OF MARYLAND

		AGE														
		TOTAL			0 - 4			5 - 19			20 - 64			65+		
Degree of Retardation		MILD	MOD.	PRO.	MILD	MOD.	PRO.	MILD	MOD.	PRO.	MILD	MOD.	PRO.	MILD	MOD.	PRO.
Percentage		2.6%	0.3%	0.1%	2.6	0.3	0.1	2.6	0.3	0.1	2.6	0.3	0.1	2.6	0.3	0.1
AREA I	1960	46,897	5,410	1,804	5,427	626	209	12,433	1,434	478	25,490	2,937	979	3,545	405	135
	1965	51,033	5,888	1,963	5,478	631	209	15,047	1,736	579	26,502	3,057	1,019	4,006	459	153
	1970	55,484	6,402	2,134	6,064	699	234	16,319	1,883	628	28,598	3,297	1,099	4,502	522	174
AREA II	1960	18,156	2,095	698	2,366	273	91	5,338	615	205	9,596	1,104	368	856	99	33
	1965	22,069	2,547	849	2,572	297	99	6,912	798	266	11,535	1,334	444	1,051	120	40
	1970	26,883	3,102	1,034	3,143	363	121	8,158	941	314	14,296	1,647	549	1,288	147	49
AREA III	1960	6,961	805	267	708	82	27	1,913	219	73	3,664	423	141	679	81	27
	1965	7,203	831	277	715	83	28	1,942	224	74	3,820	437	146	727	84	28
	1970	7,410	854	284	723	83	27	1,908	221	74	3,997	462	154	781	90	30
AREA IV	1960	6,333	730	244	691	79	27	1,717	198	66	3,242	369	123	686	78	26
	1965	6,709	774	258	716	83	29	1,839	212	71	3,437	395	131	713	84	28
	1970	7,079	816	273	761	87	30	1,931	223	76	3,644	420	140	742	87	29
AREA V	1960	2,270	262	88	338	40	13	747	87	29	1,061	123	41	125	16	5
	1965	2,584	299	100	365	43	14	858	99	33	1,230	141	47	134	15	5
	1970	2,898	335	112	371	43	14	950	110	37	1,426	165	55	149	15	5

Maryland State Planning Department
1960 Census Data

Table V. SUMMARY OF IDENTIFIED MENTALLY RETARDED PERSONS RECEIVING SERVICES IN MARYLAND: 1965

I. EDUCATION [1, 2]			
1. Public Schools		22,487	
2. Private Schools		1,010	
3. Assignment unknown		3,740	
		27,237	27,237
II. SHELTERED WORKSHOPS AND OCCUPATIONAL TRAINING			189
III. DAY CARE AND NURSERY CENTERS			386
IV. RESIDENTIAL			
1. Rosewood State Hospital-School age[2]	1,195		
2. Rosewood State Hospital		2,467	
3. Henryton State Hospital		343	
4. Private		298	
		3,108	3,108
V. DIAGNOSTIC AND EVALUATION CENTERS [3]			
1. Baltimore City	400		
2. Rosewood State Hospital	235		
3. Health Department-Mobile Team	97		
4. Waiting lists*	200		
	932		
VI. MARYLAND PENAL INSTITUTIONS*			706
VII. MARYLAND TRAINING SCHOOLS*			350
VIII. STATE MENTAL HOSPITALS*			700
IX. VOCATIONAL GUIDANCE, TRAINING, AND CONSULTATION [3, 4]	375		
X. DEPENDENTS OF MILITARY PERSONNEL [3]	90		
TOTAL [5]			32,676

[1] Either in regular public school classes, day care programs, or placement unknown.

[2] Excluding 1195 school age residents of Rosewood State Hospital-listed under IV-1.

[3] Not included in total; these individuals may be counted in other categories.

[4] State Department of Education: Division of Vocational Rehabilitation.
SOURCE: Maryland State Construction Plan. State Board of Health and Mental Hygiene, 1965. Agency Mental Retardation Planning Committee representatives.

[5] 0.9% of Total Population.

*Estimates.

A PLAN FOR MENTAL RETARDATION SERVICES

The outline of goals, present services, and needed services which follows was written by the Planning Committee on Mental Retardation using the report of the Office of Mental Retardation Planning as its resource document. The analysis and recommendations represent the consensus of the entire committee except in those few instances where a minority opinion is noted. These differences, though few, are important because they represent lack of agreement between agencies and professional groups which must be resolved before comprehensive programming can become a reality.

Readers desiring more details or background data are referred to the Office of Mental Retardation Planning report; its extensive compilation of data and detailed professional opinions is far too lengthy to be reproduced here. It should also be noted that in some instances a type of service is discussed with the age group where it is of the greatest concern; this does not mean that the service is or should be limited to that age group.

Philosophical Positions and Recommendations Applicable to Mental Retardation Planning for All Age Groups

A. Implementation of the Comprehensive Mental Retardation Plan is the responsibility of all the citizens of Maryland. The Planning Committee found that when attention was focused on services needed, there was little need for legislative change. The Plan can be implemented by the present structure of State Government, provided it receives the unqualified support and cooperative effort of the Governor, the Legislature, the various State agencies, and the voters of our State in providing sufficient funds for the services required.

B. Primary emphasis must be placed on efforts towards the prevention of retardation. This includes both basic research aimed at the prevention of causes and a concentration of services to the retarded individual and his family *early* in the life span. The benefits of such service will be magnified many times in terms of the reduction in human suffering and the expenses of inappropriate use of residential care services. *Note*: Traditionally, state governments have not taken an active role in supporting basic research, leaving this responsibility to the Federal Government and private foundations. It is hoped that our State Government might alter this pattern by including research needs in future agency budgets. Such a change would stimulate the talents of the many expert professionals in State service, make Maryland a very attractive place for new professional men and women, and result in better service to our retarded citizens.

C. Administration and coordination of services for the retarded will not prove to be a difficult problem if approached from an attitude of cooperation. There is no need for any new agencies or for large quantities of new legislation and regulations. Cooperation between agencies can be achieved by two basic steps:

1. Both the Governor's Inter-Agency Commission and the present Planning Committee of practicing professionals at the program level in the field of mental retardation should continue to meet, the latter on a monthly basis. Between them, these two groups can assure continuity in program development.
2. For each stage of the retarded person's life one agency should be given primary responsibility for providing or obtaining services; the principal responsible agency will obtain from other agencies those special services which they are professionally competent to provide.

D. Agencies providing services for the mentally retarded should be aware of their areas of greatest professional competence. Implementation of this philosophy will require that all persons think beyond traditional approaches of individual agencies as they now exist. Opportunities to begin implementing this philosophy will present themselves during the transitional period through modification and adjustment of existing programs. Program levels could be raised if special services were obtained from agencies best equipped to provide them. For example, educational programs should be operated by the State Department of Education and the local boards of education; conversely, school health facilities should be operated by the county health departments; the Department of Welfare should take more responsibility for obtaining foster placements, giving financial assistance, and cooperating with the State hospitals in this obligation; home visiting of families with retarded children should be organized by the Department of Welfare. These are but a few examples of the principle of agency responsibility and cooperation. The basic areas of responsibility can be summarized in three statements:

1. Prevention and treatment of the diseases and physical conditions causing and relating to mental retardation in the community are the concern of the Department of Health.
2. Education and training of the mentally retarded are the responsiblity of the Department of Education and the Division of Vocational Rehabilitation.
3. Twenty-four hour care and support services are vested in the State Departments of Mental Hygiene and Public Welfare.

E. The mechanisms of evaluation research must be built into all new programs. If this is not done, the projects value will never be known; and economy of programming will suffer.

F. The regional approach is appropriate for and should be utilized in areas of sparse population to provide certain services not otherwise feasible. Services should be provided as close as possible to where the retarded live with a minimum of dislocation. Greater impetus needs to be given to the development of small regional residential centers. Community services should be provided for most retarded persons with residential services being utilized for observation, evaluation, and for treatment and training of problematic cases.

G. Barriers which make general community services unavailable to the mentally retarded persons should be removed. The retarded should have access to all services which are applicable to his needs, and if these fail to meet his needs, enriched or special services should be provided so that each retarded person may develop to his full potential.

H. A continuum of service must be provided so that no individual is lost in the transition from one stage in his life to another.

AGE: 0-1

I. GOALS

A. *Prevention*: The prevention goal at this age as well as in the prenatal period is to prevent retardation by preventing the diseases and accidents which cause it. It is in the area of retardation caused by disease that the most promising area of prevention lies. Progress in the field of genetics and genetic counseling opens another area of possibili-

ties. If preventive measures are to be effective, early detection is an absolute necessity.

B. *Diagnosis*: The main goal of diagnosis at this age is detecting retardation, if possible; another important goal is the detection of diseases which may cause retardation.

C. *Treatment:* At this stage of research retardation is medically incurable. It can in some cases be ameliorated as to its effects by education and training or even sensory stimulation; but retardation is the result of disease or trauma and not a disease itself. We can often treat and cure the disease itself thus preventing the retardation.

II. PRESENT SERVICES

A. *Prevention:* Present services related to prevention of mental retardation during the prenatal and infant period:

1. Prenatal and infant care are supplied on a very rudimentary basis to about 10 per cent of those needing these services.
2. *Immunization:* Only smallpox inoculation is compulsory at the present time.
3. *Screening:* The only effective screening program directly affecting mental retardation in current use is the screening program for Phenylketonuria. The present blood test assures about 90 per cent coverage.

B. *Diagnosis:* Almost all diagnosis both of causative conditions and of mental retardation itself is done by the family physician. A few counties have pediatric consultation available through the health clinics.

C. *Treatment:* For many of the diseases and conditions causing mental retardation treatment is available; earlier and more effective screening and diagnosis are needed.

III. NEEDED SERVICES

A. *Prevention*

1. Prenatal and infant care need to be increased; a public campaign should be undertaken to increase the use of existing health clinics.
2. Cooperative home visiting should be undertaken by the Department of Health and the Department of Welfare to all homes in which there are mentally retarded children or adults.
3. Local school boards should set up parent education programs dealing with mental retardation.
4. Genetic counseling should be provided through the local health clinics.
5. More information about the relevant aspects of family planning should be made available through the local welfare departments and the public health nurses.

B. *Diagnosis*

1. Pediatric consultation should be made available at all county and city clinics.
2. Broader screening techniques need to be applied in hospitals and clinics.
3. Health education of both professionals and laymen needs to be promoted in the area of mental retardation.

C. *Treatment*: In addition to medical treatment techniques there is need for more foster care homes of an adequate nature and some foster group homes. More will be said later about the foster care needs of adults.

AGE: 2-4 (inclusive)

I. GOALS

A. *Prevention:* The preventive efforts needed for this age group represent a continuation of the initial services of prevention in the preceding group (0-1) with the addition of one new major aspect. The possibility of preventing many cases of mild retardation is a real possibility.

1. *Severe and Profound:* Most of these cases are identifiable in infancy and are no longer preventable at this age. Good child care practices will reduce the number of cases due to trauma and disease. With those cases already identified, prevention becomes a matter of preventing secondary effects and what could be complicating secondary handicaps.
2. *Moderate:* Some of these cases will already have been identified during the 0-1 age. Other cases will be identifiable at

this age. Some caused by disease, accident, etc., are preventable.

3. *Mild Retardation*: Mildly retarded children do not appear to be abnormal at this age; such retardation becomes evident and a problem when the child enters school. This mild retardation has three causes:
   a. Diseases and accidents.
   b. General medical problems and especially hearing problems which remain unattended.
   c. Deprivation due to social, cultural, and emotional factors.

Retardation of the mild variety is largely preventable during the 2 to 4 age span because this type of retardation is clearly linked with speech development and intellectual development dependent on the early use of language and symbolic behavior in general. One of the best and simplest forms of prevention is adequate child care and health services generally.

The problem of cultural deprivation and mental retardation is somewhat more complex. The more pragmatic position would seem to be the most tenable one, viz: children who, at any given time, are functioning as retarded should be categorized as retarded and given service. If their level of functioning is sufficiently raised to place them within the range of normal functioning, then the condition should be considered ameliorated. The distinction between severe cultural deprivation and mild mental retardation is of little use from the point of view of prevention and service. Extended differential diagnosis can distinguish between the two at least by school age. Such diagnosis is hardly feasible when both costs and numbers of children involved are considered. *The goal with culturally deprived children is to give them sufficient sensory and cultural stimulation beginning at age two to prevent the effect of deprivation from developing into retardation.*

Once a deprived-retarded child reaches school age, dramatic amelioration of functioning level is no longer possible. Special classes for the mildly retarded without additional supporting services do not appreciably ameliorate mental retardation; the best they can do is improve the retarded child's chances for later success in society. That dramatic changes in level of intellectual functioning can occur in earlier age groups has been amply proven by several major pieces of research. The most significant of these was the Champagne-Urbana study[5] in sensory stimulation of young retarded children.

B. *Diagnosis*
   1. *Severe, Profound, and Moderate Retardation:* The diagnostic goals at this age are approximately the same as for the preceding age group. Some additional referrals for diagnosis will come from parents and family physicians who become aware of abnormal delays in development. These cases should all be examined for possible retardation.
   2. *Mild:* A diagnosis of retardation of the mild sort should not be made at this time. The child who has sensory problems or is suffering the beginnings of deprivation should be picked up and screened for treatment in the preventive program. By this means, a diagnosis of retardation may become unnecessary.

C. *Treatment*
   1. *Severe and Profound:* A large number of cases of severe and profound retardation will require residential care. Many families, because of varying circumstances, will not be able to care for such children much beyond their earliest years. Some possible alternatives to residential care would be group foster homes, community day care centers for the younger age groups, and activity centers for older groups.
   2. *Moderate:* For this group of retarded children, complete cure or total amelioration of retardation is not usually a reasonable goal, although with early involvement in suitable programs, a considerable degree of habilitation is quite possible. (The possibility of inaccurate diagnosis and prognosis in regard to the intellectual potential of young children demands great care in evaluation, if serious consequences are to be avoided.)

      This group of retarded children already exhibits developmental problems sufficient to indicate that a training pro-

gram is needed.[6] These children need a twofold program of training: help in acquiring the skill of daily living and stimulation to aid sensory development and language development. Along with this training program, they require a wide range of special health services aimed at preventing the development of complicating secondary handicaps. Since most of these children can remain at home, if such a treatment program is available in the community, the implementation of this program will be less expensive than long-term residential care.

3. *Mild:* It was stated above that mild retardation should not be diagnosed as such at this age. We are here dealing with a treatment program for deprived children aimed at preventing cultural deprivation from leading to retardation.

   The program referred to should also be open to all children, regardless of environment, who are exhibiting developmental delays which place them within a mildly retarded range of functioning. The program for these children would be aimed at isolating and, if possible, overcoming their specific developmental problems, especially in the area of learning. The treatment program for this entire group should make available the following services depending on the need of each individual child:

   a. Medical and dental care
   b. Vision and hearing corrections
   c. Speech pathology services
   d. Training in daily living skill
   e. Programmed training in language development (remediation of subcultural language patterns)
   f. Experience in self-expression through play and conversation.
   g. Nutritional services
   h. Involvement of parents through counseling, mother helping in program, session for parents, etc.
   i. Clothing aids

   Such a program will remove the need for many special services to the mildly retarded in school years, since it will enable many of these children to function within the normal range of behavior and to take their place in the regular classrooms.

II. PRESENT SERVICES

Present services are available in a widely varying array, often inconsistent with needs and generally smaller in scope than required.

A. Residential care for the severely and profoundly retarded is provided at Rosewood State Hospital and Henryton State Hospital.

B. Special diagnostic and evaluation services are provided through certain county health clinics, as well as through the central clinics located at University of Maryland and The Johns Hopkins Hospital. These clinics need to be expanded to include all local health departments throughout the State.

C. Day-care centers for the severely and profoundly retarded are operated by the Department of Health in many places throughout the State. These centers began in 1961 and have grown as the community need has presented itself. This is not to infer that, at the present time, all age groups are being served adequately.

D. Preschool programs of the "Head Start" variety are operated through the local boards of education under Federal Anti-Poverty Legislation. These programs are aimed at the needs of deprived children. They need to be broadened in scope to include diagnostic, clinical, and health services, as well as to include younger age groups. The initial results of these programs are encouraging.

E. Family services are provided mainly by the Department of Welfare (and a few private agencies). These services are basically sound but need to be increased and expanded to include specific aid in child care guidance to families with retarded (moderate, severe, and profound) children who, because of income levels, are not entitled to welfare services. The Department of Welfare family services need also to be coordinated with the day-care and preschool programs.

F. The community mental health centers serve an important function as one of the consultation services to individuals who present

associated emotional or behavioral problems requiring specialized psychiatric help.

III. NEEDED SERVICES

In order to coordinate present services as well as to expand them to meet needs, the following plan for a comprehensive preschool program for *retarded and deprived* children is proposed. This comprehensive program could be started by combining under a cooperative effort several already existing programs: the day care centers operated by the health departments in many places throughout the State, the preschool classes for handicapped children in Anne Arundel and Washington counties, and the "Head Start" projects operated with the help of Federal funds by the local boards of education.

A. Preschool centers for retarded and deprived children should be established in communities throughout the State. Four groups of children would be served in these centers:

   1. Severely retarded children from all families
   2. Moderately retarded children from all families
   3. Children with specifically diagnosed developmental delays
   4. *Culturally deprived children:* All children aged 2 to 4 from families who are either on the Department of Welfare rolls or who fall within the poverty limits as defined by Federal law.

B. These community centers would provide the following services:

   1. *Diagnostic and evaluation services:* A diagnostic team consisting of a pediatrician, psychologist, educator, and social worker would operate large comprehensive evaluation clinics from these centers.
   2. *Health and clinical services:* These services would be provided to all children involved in the program but would be dependent on the ability of their parents or guardians to pay. Such services would include: medical, dental, visual, and auditory correction, inoculation, etc.
   3. *Family services:* Social work services to the families would be provided by the Department of Welfare and would include home assistance in problems of raising retarded children, assistance with general child care and home management problems where needed. Involvement of mothers in the program at the center is also desirable whenever possible.
   4. *Educational and training services:* Services specific to the four types of children in the program would be provided by the local Department of Education. This program would be staffed by teachers trained in special education along with teacher aides.

C. *Administration and organization*

   1. It is imperative that each agency involved (health, mental hygiene, education and welfare) provide those services which they are best equipped professionally to provide. Coordination of services is required, but excessive overlapping of services should be avoided. Some apparent overlapping is necessary to prevent gaps in services.
   2. One agency should have major responsibility for the program receiving special services from other agencies. The local boards of education appear to be the most practical choice for coordinating agencies since it is likely that the centers would be placed adjacent to schools.

      The choice of a coordinating agency, although important, is not nearly so important as having each agency provide and be professionally responsible for those services that are within its area of professional competence.

Note on Minority Opinion: The State Department of Health, through its representative on the Planning Committee, while subscribing to the general philosophy of professional separation and responsibility stated above under "Philosophical Positions," objects to its application to the day care centers as now operated by that Department. The remainder of the members of the Working Committee are unanimous in feeling that the Department of Health should transfer the education and training aspects of the day care centers to the State Department of Education as the agency best able to provide professional supervision.

AGE: 5

In the preceding section (age 2-4) a broad program of preschool services was outlined for four types of children:

1. Severely retarded
2. The moderately retarded child
3. The culturally deprived child
4. The child with specific delays in development.

Such a program should continue at age 5. The specific goals and services to be discussed below have to do with *school admission* in general. The transition between the preschool center and the school proper should be *preceded* by a full evaluation and educational planning session. Whether this occurs at age 5, 6, or 7, depends on:

1. The compulsory attendance age
2. The extension of compulsory attendance to handicapped children.[7]

I. GOALS

A. *Prevention:* By age 5, the intellectual development of the child has progressed to the extent that little more can be done by way of preventing retardation. Almost all cases of severe, profound, and moderate retardation can be identified by this time. The remainder of the cases of moderate and mild retardation become apparent when the child fails to progress in school. Present research evidence seems to indicate that prevention of these cases of retardation must occur during the 2-4 age range. From age 5 on, the only prevention involved is for those cases that would result from disease or accident.

B. *Diagnosis*: At the time of school admission, diagnosis is the most important aspect of the retarded child's program. Proper school programming should begin with the first day of school rather than beginning after the child fails the first or second grade. Complete and careful diagnosis is needed to distinguish among mild retardation, moderate retardation, deprivation without retardation, autism, hearing loss, speech defects, and emotional disturbances. Each of these different problems requires a different sort of educational program. The diagnosis, therefore, must be positive as well as negative. The child's assets and limitation must both be known so that proper treatment can be provided. None of the children involved should be made to experience school failure before receiving proper diagnostic services.

C. *Treatment:* The goals of treatment for 5-year-old retarded children are essentially the same as for the preceding age group.

1. *Severe and Profound*: Many of these children will be in community day-care and residential care facilities. In many instances, under the aegis of a sequential, developmental program, they will be capable of benefiting from fundamental training, social habit training, and occasionally some will progress to special education classes.
2. *Moderate:* If the diagnostic evaluation still indicates moderate retardation, the program of training in daily living skills and sensory development should continue as with the 2-4 age group. A few children previously in this group will now test in the mildly retarded range and be treated with that group.
3. *Mild:* This group of children will not be the same group that existed at the 2-4 age. Many of those children will now be functioning in the normal range, if the preschool program has been successful. On the other hand, some additional cases will be identified at the time of school admission. Mildly retarded children should participate in a kindergarten situation with normal children. They have a definite need for the sort of socialization and school-readiness activities which the kindergarten provides.

II. PRESENT SERVICES

A. The type of diagnostic evaluation described here is nowhere available in the State of Maryland. Every school system employs some sort of screening techniques but without sufficient follow-up evaluation. In most cases, retarded children are identified after the first or second grades.

B. The diagnostic and evaluation clinics at Rosewood, The Johns Hopkins, and the University of Maryland hospitals and the State Health Department need to be expanded. Their chief weakness, at present, is a lack of educational planning in the case report.

C. Kindergarten programs are not yet very extensive in the public schools. Where they exist, they are on a tuition basis.

D. The compulsory school attendance age of 7 is too high. This permits parents to keep children home when they could profit from specialized school programs. It also allows local schools to avoid developing special school programs for the retarded until that age.

III. NEEDED SERVICES

A. The most pressing need for additional services at this age is adequate screening programs and diagnostic evaluation at school admission.

1. After the initial screening, all children suspected of a mental handicap should receive a detailed diagnostic evaluation. The examination should include the services of a physician, a psychologist, and an educator. In many cases, a psychiatric or neurological examination will also be necessary. Coordination of this service should be the responsibility of the local health departments.
2. All children previously identified as moderately retarded along with all culturally deprived children served in the 2-4 program should be reexamined by the same diagnostic team.
3. These examinations should be required for school admission as is the smallpox vaccination.

B. Kindergarten programs should be provided free by the public schools to all retarded children starting at age 5. The mildly retarded should attend with normal children. A separate program will have to be provided for moderately retarded children.

C. Compulsory school attendance laws should include the retarded down through age 5. Exception should be made only for children who present a health or sanitation problem or who are totally unmanageable. Day-care services will need to be provided for some of the profoundly and severely retarded.

D. The three major diagnostic and evaluation clinics at Rosewood, The Johns Hopkins, and University hospitals should provide free service to all and should include an educational diagnosis. The advent of the full team for diagnosis and evaluation will alter the role of the three major clinics to greater specialization in more problematic cases.

E. The possibility of kindergarten admission at age 5 on a monthly basis should be considered for the retarded (and possibly for all children). This system would allow a smooth spacing of examinations and school registration. One reason for the present lack of preschool diagnosis is the annual rush at the time of school registration.[8]

AGE: 6-12 (inclusive)

I. GOALS

A. *Prevention:* The goals of prevention from this age on are basically concerned with preventing the effects of retardation. The retarded child must be helped to develop his positive assets to the fullest possible extent in spite of handicaps. In this way, most mildly and moderately retarded children can become at least partially self-supporting members of the community. Many can become fully self-supporting for at least a part of their lives. Investments in the prevention of the effects of retardation have both a humanitarian and economic implication. Residential care should be viewed as a community resource which provides evaluation and treatment services for problematic cases requiring both short- and long-term care. Long-term care is required only for those who cannot remain at home due to specific circumstances.

B. *Diagnosis:* Initial diagnostic evaluation must be followed by an appropriate program. The importance of the periodic follow-up evaluation must not be overlooked. Periodic reevaluations are needed for two reasons:

1. Changes in the individual child's program must be made as his level of functioning changes. If early programs have been successful, such changes may be expected.
2. Reevaluation of retarded children at frequent intervals is needed in order to provide the necessary data for proper evaluation of the programs themselves. Baseline data are necessary to analyze programs of treatment that appear to be ineffectual.

C. *Treatment:* The treatment goal for school age retarded children is to give them the best chance possible to develop into adequate or nearly adequate members of society. There are three areas which need special attention:

1. *Health services:* Many retarded children have special health problems, including multiple physical handicaps. In the case of mildly retarded children from poor environments, the general health problems associated with deprived neighborhoods are encountered. Poor health situations are apt to compound the already existing handicap.
2. *Family Services*: Most parents of retarded children want to keep their children at home at this age. This is possible if they have access to knowledge about the care and training of retarded children in the home. As the family grows older, these children present increasingly difficult problems rather than easier ones.
3. *School Services:* A few mildly retarded children can learn with normal children. Most retarded children, however, will continue to require special school programs. The goals of these school programs are: Socialization, language and communication skills, and training for economic usefulness. When compulsory attendance laws first began, retarded children were excluded as being unable to profit from public education. It is now recognized, however, that the presence of the retarded child in school is beneficial to both him and other children provided he is given a program to meet his needs.

II. PRESENT SERVICES

A. *Health Services:* At present, health services to the retarded can be described as fair. Some families of lower income need financial aid to obtain special health services for their retarded children. Private physicians do a good job of treating retarded children and they should continue to be the primary source of medical services for retarded children living at home.

B. *Family Services:* These are at present almost nonexistent. There is no group of family or child care workers in the community with the special training needed to help parents of the retarded. Primary responsibility for this service should be given to the Department of Welfare.

C. *School Services:* Every county and Baltimore City have some special classes for handicapped children. Retarded children are enrolled in classes for the retarded as well as in classes for children with specific learning problems. School reports indicate that 70 per cent of the retarded children identified are enrolled in special classes. The weakness of the present school program is two-fold:

1. *Lack of trained personnel:* Only 50 per cent of special class teachers are fully certificated.
2. *Overcrowded classrooms:* This is especially the case in Baltimore City where financial problems in the school system have resulted in overcrowded conditions in all classrooms. Baltimore City has a large waiting list of moderately retarded children awaiting school admission.

The 70 per cent enrollment figure includes the Rosewood State Hospital School and private and parochial school placements. For retarded children below the mild level, the State Department of Education provides partial tuition support to the families of the children, when private school is required. Increased efficiency in identification and evaluation will initially increase the need for special class expansion. Eventually the preschool program should reduce the need for so many special classes for the mildly retarded, especially in Baltimore City.

III. NEEDED SERVICES

A. *Health Services:* The possibility of medical aid to families of retarded children should be considered. This could be in the form of medical care through the Department of Welfare or in the form of services through local health clinics. It would seem preferable that aid be given to the families so that they might obtain services from their family physician.

B. *Family Services:* Families of retarded children should be eligible for family services from the Department of Welfare. Special workers will have to be trained in the area of mental retardation in cooperation with the Department of Health to meet this need.

C. *School Services:* Several steps need to be taken to improve the school program:

1. The compulsory attendance law has been extended to include retarded children. The school should be left with the discretionary authority to exclude only those children who are physically or socially unmanageable.[7]

2. Increased State aid should be given to the development of teacher training programs in special education. The second undergraduate program in mental retardation in Maryland was opened last year at Coppin State College; the only other such program is at the University of Maryland. This program should be expanded to make Coppin a teacher training center for teachers of all types of handicapped children. This would be preferable to having small, poorly staffed programs at other State Colleges. The Coppin program, along with the program at the University of Maryland, would provide two centers for the training of special class teachers. An Associate of Arts program for teacher aides, case workers, and preschool workers should also be introduced at Coppin and the University. Since the greatest need for additional personnel in mental retardation work will be in the City, Coppin's location makes it an ideal center for this purpose.

3. Multicounty supervisory services should be set up on a contractual basis to provide more local educational supervisors in special education to update curricula and methods. The smaller counties cannot afford supervisors trained in mental retardation on an individual basis.

4. State aid for classes of handicapped children should be extended to include classes for the mildly retarded. The amount of this aid should be increased to cover actual costs. (This would greatly reduce the need for more expensive private programs.) Current actual cost is $1,300 per class.

5. Curriculum and methodological changes should be made in classes for the retarded to include more *behavioral conditioning techniques* and more *prevocational training.*

6. The school at Rosewood State Hospital should be expanded as there are children in the hospital capable of profiting from school programs who are now excluded due to limitations of staff and space. The school also lacks sufficient consultative staff to provide needed reevaluations.

IV. RESIDENTIAL CARE

The need for residential care for school-age retarded children other than those in the profound and severe categories is usually due to some other problem than retardation alone. Typically there is an associated physical or emotional handicap. Often the need for residential care arises from family problems. Social work services are needed to provide basic liaison with the community and to enhance the possibility of early community placement.

Overcrowding, understaffing, and outdated building design prohibit optimal programming at Rosewood State Hospital; the general level of care is as good as could be expected under the circumstances. The school program is educationally sound but is not nearly large enough to supply education and training to all the mentally retarded persons at Rosewood capable of profiting from them. More attention should also be given to those special services aimed at removing the immediate need for residential care. Terminal, full-time residential care should not be used for those who do not really require it.

In recent years, the Department of Mental Hygiene has been providing a program of temporary admission to Rosewood and Henryton State Hospitals for retarded children and adults who are living in the community. This program permits parents and guardians of the retarded to have a temporary respite from their responsibilities for short periods, usually in the summer. This program should be more widely publicized and utilized. Residential facilities should provide day-care services for the community.

AGE: 13-19 (inclusive)

I. GOALS

A. *Prevention:* The goals for prevention for the 13 to 19 age group can be summarized by saying that the aim of programs for teenage retarded members of the community is to train them for as much later independence in the community as is reasonably possible.

Preventive efforts are aimed at preventing the one specific effect of retardation which is most serious—overdependence on others both economically and personally.

B. *Diagnosis:* Reevaluation should continue throughout this age range. Of new importance at this age is the need for a complete range of prevocational aptitude tests. These are necessary so that the last years of school training may consist of appropriate vocational preparation.

C. *Treatment:* Adequate prevocational training is the goal at this age. This includes specific job skill and also work habits and social adjustment.

D. *General Note on the Provision of Services to the Retarded:* From age 13 on through adulthood it should be noted that there is a distinction to be made between making a retarded person eligible for special services and making him in any way dependent. The purpose of providing him with supportive services in the community is not to impair his freedom or hinder him in any way; it is rather to make his freedom in the community possible while protecting him from such problems of living as he might not be able to take care of without help.

E. *Delinquency among Retarded Youth:* Retarded young people (including the mildly retarded) who commit crimes or who are adjudicated delinquent should receive special programs of behavioral training. These programs should be geared to the special needs of this group. The fact of special class placement in school in a class for retarded children should be *prima facie* evidence of mental handicap and should be taken into account *at the time of the trial or juvenile hearing.* Pretrial evaluation by a full diagnostic and evaluation team knowledgeable in mental retardation should be required in all cases.

II. PRESENT SERVICES

A. *Secondary School Classes for Mildly Retarded Adolescents*: These are prevocational classes in secondary schools. Where they exist (Baltimore City and about one-third of the counties), the curriculum is basically sound. An adequate aptitude testing program is lacking. Some school systems still lack a well-defined "leaving" system for these classes. Some give diplomas, others give certificates of attendance. Many of the students leave these classes upon reaching their sixteenth birthday.

B. *Classes for Moderately Retarded Adolescents:* These classes are generally not held in the secondary school. They are usually an extension of the elementary classes for moderately retarded children. Again, the "leaving" system needs improving. Many of these children leave the class, return to their homes, and do nothing for several years. When they are picked up by Vocational Rehabilitation, they have already lost much of what they had learned in the school program. A similar gap exists between the school program and the Vocational Rehabilitation program at Rosewood State Hospital.

C. *Day-Care and Activity Centers:* These centers are operated by the Department of Health in Baltimore City and twelve of the counties. Retarded adults require various types of support services. The State Department of Health is operating some adult activities centers on the day-care model. Sheltered workshops for the most part have been sponsored by private organizations, usually the Maryland Association for Retarded Children and Goodwill Industries, Inc., with services purchased by the Division of Vocational Rehabilitation.

D. *Henryton State Hospital:* This new State hospital is conducting a rehabilitation and training program for retarded youth and adults. The program is an extremely intensive one designed to facilitate the movement of moderately and severely retarded persons into community placements.

E. Vocational Rehabilitation has been expanding its services during the past two years. Mentally retarded youngsters now become eligible at age 15. Until recently, lack of staff and community facilities have prevented adequate coverage of the potential case load of retarded clients. This situation is rapidly being remedied. In consonance with the expansion of the Vocational Rehabilitation program, joint programs are being set up by the schools. These are truly cooperative programs between Vocational Rehabilitation and the local schools.

F. The Maryland Children's Centers were designed to be study centers for delinquent adolescents available to the courts for pre-trial evaluation. In spite of the existence of these facilities, mentally retarded adolescents can still be found in training schools for delinquents. All of the cases in these institutions are of the mild type; but even for these children this is an inappropriate placement. It is possible to transfer a child from a training school to Rosewood, but this may be an involved process, which may sometimes take several months. Furthermore, it is still possible for a retarded child to be transferred to the jurisdiction of criminal court for trial and sentencing.

III. NEEDED SERVICES

A. The secondary school program for mildly retarded adolescents in cooperation with Vocational Rehabilitation should be expanded as follows:

1. These programs should be expanded numerically to cover all mildly retarded adolescents.

2. The work-study program should include the awarding of a diploma based on completion of a definite program sometime between age 16 and age 21. This should not be interpreted as excluding the individual from further programs of training and vocational rehabilitation.

3. The Vocational Rehabilitation program should be extended downward in age to age 13. At this age, Vocational Rehabilitation should officially list the child on its rolls and administer a complete battery of aptitude tests in addition to accumulating data necessary for the establishment of eligibility. The final years of the secondary program should be based on the results of these tests coupled with a realistic evaluation of the community employment situation.

B. Similar close cooperative program should be set up between Vocational Rehabilitation and the school programs for moderately retarded adolescents.

C. A broad program of sex education for the retarded needs to be developed and implemented. Parents have shown little inclination and less ability in this area and the school curricula in general do not cover the subject well if at all. This program should be begun in the home with the assistance of the family worker from the Department of Welfare. It should be continued in the school as a full section of the curriculum at several different levels. For retarded youth in institutions, the program should include in-service training of the related members of the cottage staff. Since these workers have close contact with the retarded, their cooperation in a program of sex education is essential.

D. Delinquent adolescents who are mentally retarded should be referred to a special training program which should be developed at Rosewood State Hospital. Any child who has been placed in a special class because of mental retardation should be ineligible for training school placement. If transfer to criminal court is necessary, and commitment to a correctional institution follows, the offender should be transferred to Rosewood or Clifton T. Perkins hospitals. If proper pre-trial of delinquents suspected of mental retardation is to become available to the courts, full use must be made of presently existing and future evaluation centers which are properly staffed. These centers should include Rosewood State Hospital, Clifton T. Perkins State Hospital, The Johns Hopkins and the University hospitals, local retardation and mental health centers and the Maryland Children's Centers.

E. Sheltered workshops should be supported by Federal, State, county, and City Governments as well as cooperative agreements by a combination of these political entities and nonprofit organizations. In some cases, these workshops may operate at a loss, but this loss is more than compensated for by savings in care. Greater emphasis needs to be placed on including more severely retarded in sheltered workshop programs. An awareness of the full potential of the severely retarded is slowly being achieved.

F. *Recreation:* Retarded adults should be able to participate in community recreation programs with a minimum of program modification. Community recreation programs should plan for and offer special activities for retarded citizens.

AGE: 20-44

I. GOALS

A. *Prevention:* The goal for this age group consists of helping the retarded adult live in the community as long as possible by giving him the support services he needs.

1. Profound: The goal for the profoundly retarded is improved physical care.

2. Severe: The goal for the severely retarded is improved physical care with sensory development and training in order to obtain increased level of functioning.

3. Moderate: Most moderately retarded adults can live in the community on a partially independent basis. Some can make a partial contribution to their own economic support through subsidized industry.

4. Mild: Almost all mildly retarded adults will be found in the community. If early programs of education and vocational rehabilitation prove successful, many of those people will become independent supporting members of the community and will, in this sense, no longer be classified as retarded.

II. PRESENT SERVICES

A. Retarded adults are currently eligible for rehabilitation services. Recent expansion of this area has enabled more case coverage. Almost all profoundly retarded adults are in a State-operated residential facility.

B. Provisions for residential care of the profoundly and severely retarded at Rosewood State Hospital and Henryton State Hospital seem to be adequate. Provisions are also available for temporary admission of non-institutionalized retarded adults.

C. Foster care and guardianship services for moderately retarded adults are available, but these services are limited as to quality and quantity.

D. A growing awareness of the problem of mental retardation is apparent in our courtroom procedures, but too many mentally retarded men and women are still being sentenced to correctional institutions (currently 706).

E. The Department of Employment Security provides limited service in locating employment for retarded adults.

F. Some retarded adults are receiving services in the Department of Health day-care centers; this form of service is not yet as extensive as it should be.

III. NEEDED SERVICES

A. All identified mentally retarded adults should have the benefit of vocational rehabilitation assessment and evaluation for determination of eligibility for rehabilitation services and should receive them whenever they are eligible.

B. The greatest need in service for retarded adults is an expansion of the foster care and guardianship program. A campaign should be initiated to find foster parents or group foster homes for retarded adults in the community. Incentives for persons in the community who take on the responsibility of guardianship of property should be provided in a realistic manner. The qualifications for guardianship can be more readily established through such an approach.

C. A joint program for the employment of the retarded should be undertaken by the Department of Employment Security and the Division of Vocational Rehabilitation. The operating mechanism for such a service already exists in the form of an agreement between these two agencies regarding handicapped persons in general.

D. Further use should be made of available programs of temporary admission to Rosewood and Henryton State hospitals and any other future programs that are developed.

E. The Division of Vocational Rehabilitation should provide programs of short-term vocational training for retarded adults at Rosewood and Henryton State hospitals and other residential facilities to be developed in the future. The mechanism for this has already been made operative at Rosewood State Hospital.

F. More small residential care institutions are needed throughout the State; such facilities put residential care on a more easily accessible basis. Community ties are difficult to maintain if patients must travel over fifty miles to obtain residential care. Several facilities of this type have already been proposed by the Department of Mental Hygiene.

G. Ideally, all mentally retarded persons who commit crimes should be treated in facilities for the retarded; however, since this may not be immediately feasible, the Department of Correction, in the meantime, should set up a special program of rehabilitation and training for retarded inmates, *including the mildly retarded.* At present, these inmates do not receive either sufficient education or sufficient training because of their employment in the State Use Industry System.

AGE: 45 and over

There is no essential difference as far as need for services is concerned between this and the previous age group. All services discussed for the previous group will continue throughout adulthood. The need for nursing homes and other geriatric services will probably occur sooner with certain segments of the retarded population than with the normal population; the services required, however, are identical.

STATE AGENCY RESPONSIBLE FOR SERVICES—AGE GROUPS

Principal Agency	0-1	2-4	5	6-12	13-19	20-44	45+
Education Department	Parent Education Programs	Preschool Classes "Head Start" Program Socialization Training in Daily Living Skills Language Sensory Stimulation	Preschool Classes "Head Start" Program Socialization Training in Daily Living Skills Language Communication Skills Sensory Stimulation Kindergarten	School Services Special Classes Socialization Language Communication Skills Sensory Stimulation	School Services Special Classes Socialization Prevocational Training	School Services Special Classes Evening Classes	Evening Classes
Health Department	Prenatal and Infant Care Pediatric Consultation Genetic Counseling Diagnosis PKU Screening Initial Screening Home-nursing	Day Care Centers Medical and Dental Care Vision and Hearing Correction	Day Care Centers Medical and Dental Care Vision and Hearing Correction	Day Care Centers Medical and Dental Care Vision and Hearing Correction	Day Care Centers Medical and Dental Care Vision and Hearing Correction	Day Care Centers Medical and Dental Care Vision and Hearing Correction	Day Care Centers Medical and Dental Care Vision and Hearing Correction Geriatric Service
Mental Hygiene Department	Residential Care Diagnosis Guardianship Foster Care Foster Group Homes Small Residential Centers	Residential Care Diagnosis Guardianship Foster Care Foster Group Homes Small Residential Centers	Residential Care Diagnosis Guardianship Foster Care Foster Group Homes Small Residential Centers	Residential Care Diagnosis Guardianship Foster Care Foster Group Homes Small Residential Centers	Residential Care Diagnosis Guardianship Foster Care Foster Group Homes Small Residential Centers	Residential Care Diagnosis Guardianship Foster Care Foster Group Homes Small Residential Centers	Residential Care Diagnosis Guardianship Foster Care Foster Group Homes Small Residential Centers
Division of Vocational Rehabilitation					Vocational Assessment and Evaluation of Eligibility for Rehabilitation Services Job Placement and Counseling Services to Sheltered Work Shops Vision and Hearing Correction	Vocational Assessment and Evaluation of Eligibility for Rehabilitation Services Job Placement and Counseling Services to Sheltered Work Shops Vision and Hearing Correction	Vocational Assessment and Evaluation of Eligibility for Rehabilitation Services Job Placement and Counseling Services to Sheltered Work Shops Vision and Hearing Correction
Welfare Department	Family Planning Family Services Child Care Guidance Foster Care Homes Foster Group Home Aid for Medical Care Home Visits Guardianship Clothing Aid	Family Services Child Care Guidance Foster Care Homes Foster Group Home Aid for Medical Care Home Visits Guardianship Clothing Aid	Family Services Child Care Guidance Foster Care Homes Foster Group Home Aid for Medical Care Home Visits Guardianship Clothing Aid	Family Services Child Care Guidance Foster Care Homes Foster Group Home Aid for Medical Care Home Visits Guardianship Clothing Aid	Marriage Counseling Family Services Child Care Guidance Foster Care Homes Foster Group Home Aid for Medical Care Home Visits Guardianship Clothing Aid	Marriage Counseling Family Services Child Care Guidance Foster Care Homes Foster Group Home Aid for Medical Care Home Visits Guardianship Clothing Aid	Marriage Counseling Child Care Guidance Foster Care Homes Foster Group Home Aid for Medical Care Home Visits Guardianship Clothing Aid Old Age Assistance

CONCLUSION

Maryland's Comprehensive Mental Retardation Plan comes to her retarded citizens, their families, and their friends as the best answer to years of fumbling and frustration and as the fulfillment of their dream for hope in the struggle for help with the problems caused by mental retardation. Implementation of this Plan will provide a realistic framework for a full, meaningful life for those retarded, both children and adults. It will also provide for prevention and elimination of many possible cases in the future.

Achievement of these goals, even the real and firm possibility of their achievement, comes as a harbinger of hope to all.

These goals can be achieved, to the relief of taxpayers, without new agencies being created to swell the encumbered ranks of bureaucracy, further complicating an already complex governmental structure. Services in mental retardation are expensive but lack of them is, in the long run, far more costly. This Plan places its greatest emphasis and concentrates its costly efforts in the early years of a retarded person's life, which are the years where we can speak in terms of prevention, improvement, and, hopefully, even of elimination. If a retarded person is allowed to reach adulthood without treatment, the cost is far greater and frequently results in the need for total residential care.

To all concerned with services to the retarded, the Plan does more than simply call for cooperation. It furnishes a workable mechanism for cooperation in providing services. The Plan is based upon a belief in professional competence and provides that each agency be assigned responsibility for those services which it is most capable of rendering. To assure full provision of services, one agency is designated primary responsibility in a specific stage of the retarded person's life with the additional responsibility to this agency for assuring that ancillary services from other agencies are provided. Existing agencies are fully capable and willing to provide for the needs of the retarded. All necessary funds should be used for the continuance and expansion of existent programs rather than being wasted on unnecessary additional agencies, expensive overlapping, or the development of hierarchical government structure. Reliance in the philosophy of professional competence is the best assurance for improved quality in services to the retarded.

Any plan, however well intentioned, is still a plan. It is the phase of implementation which changes the plan for hope to reality. Implementation is the concern of all and its success depends upon total support and cooperation. The hopes which now lie before us must be changed into realities through implementation of this Plan.

NOTES AND REFERENCES

1. Heber, Rick. *A Manual on Terminology and Classification in Mental Retardation,* American Journal of Mental Deficiency Monograph Supplement, April, 1961.

2. The 3 per cent figure is a statistical phenomenon derived from that area under the Gaussian Curve which is more than one standard deviation below the mean. In this sense it is accurate by definition since the Heber definition is an operational one implying a reference to the standard deviation concept. This roughly corresponds to the traditional description of a verbal intelligence quotient of approximately 70 to 75 or below.

3. Epidemiology of Mental Retardation in a Rural County: Rose County Study—The Johns Hopkins School of Hygiene and Public Health. Maternal and Child Health, Crippled Children's Service Research Grant Program, Department of Health, Education and Welfare.

4. Final Vital Statistical Tables: 1964 Maryland State Department of Health, Division of Statistical Research and Records, 9/65.

5. Kirk, Samuel. *Early Education of the Mentally Retarded.* University of Illinois Press, Urbana, 1958.

6. No distinction is being made in this report between education and training. The terms may be taken as synonomous.

7. There is a distinction between compulsory financing and compulsory attendance laws. Art. 77, Sec. 241 is a compulsory financing law. A compulsory attendance law for handicapped children was passed by the 1966 Legislature and signed by the Governor.

8. This system has been used in New Zealand ever since the advent of compulsory education there. It is extremely efficient and avoids the false assumption involved in "homogeneously" grouping young children.

DIRECTORY OF AVAILABLE SERVICES

AREA I

Facility	Sponsor-ship	Programs	Age Grouping	Level of Retardation
Angel's Haven RFD 2, Box 548 Point Pleasant Road Glen Burnie, Maryland SO 1-1588	Non-profit	Residential	School age	Moderate
Anne Arundel County Day Care Center for the Retarded, Inc. 14 Hilltop Road Annapolis, Maryland	Public	Day Care	4+	Severe
Anne Arundel County Multi-Problem Clinic for Children, Anne Arundel County Health Department Annapolis, Maryland CO 7-8151	Public (County)	Clinic	Pre-school	All
Anne Arundel County Public Schools P. O. Box 951 Green Street Annapolis, Maryland	Public (County)	Special education	School age	Educable; Trainable (Elementary)
Anne Arundel County Sheltered Workshop Earleigh Heights, Maryland	Non-profit	Sheltered workshop	18+	Mild; Moderate
Arlington Cooperative Day Nursery 7310 Park Heights Avenue Baltimore, Maryland 486-2483	Non-profit	Day care	Pre-school; School age	Mild; Moderate; Severe
Baile Hall Day Care Center, Route 1 New Windsor, Maryland NE 5-5643	Non-profit	Day care	7 to 21+	Moderate; Severe
Baltimore City Public Schools 3 East 25th Street Baltimore, Maryland	Public	Special education	School age	Educable; Trainable
Baltimore County Public Schools, Aigburth Manor Aigburth Road Towson, Maryland	Public	Special education	School age	Educable; Trainable
Baltimore Goodwill Industries, Inc. 201 South Franklin Street Baltimore, Maryland 327-1555	Non-profit	Occupa-tional center	Adult	Mild

Facility	Sponsor-ship	Programs	Age Grouping	Level of Retardation
Baltimore Goodwill Industries, Inc. 201 South Broadway Baltimore, Maryland	Non-profit	Sheltered workshop	16+	All
Carroll County Public Schools, County Office Building Westminster, Maryland	Public	Special education	School age	Educable; Trainable
Central Evaluation Clinic for Children University of Maryland Hospital 112 South Greene Street Baltimore, Maryland 955-2121	Public (State)	Diagnosis; Eval-uation	Pre-school; School age	All
Children's Rehabilitation Institute, Inc. Westminster Road Reisterstown, Maryland 833-5100	Non-profit	Education; Residential treatment	Preschool; School age	Mild
Chimes Day Care Activity Center 1813 Thornbury Road Baltimore, Maryland FO 7-0400	Non-profit	Day Care	School age Adult	All
Coppin State College 2500 West North Avenue Baltimore, Maryland	Public (State)	Undergraduate special education program in mental retarda-tion		
Diagnostic & Advisory Services for Handicapped Children, State Health Department (Mobile Clinic) Harford County Health Department Annex Revolution Street Havre de Grace, Maryland	Public (State)	Diagnosis; Evaluation	Preschool; School age	Mild; Moderate; Severe
Diagnostic Center for Handicapped Children Johns Hopkins University Hospital, 601 North Broadway, Baltimore, Maryland 955-5636	Non-profit	Diagnosis; Evaluation	Preschool; School age	All
Diagnostic & Evaluation Center for Handicapped Children Johns Hopkins Hospital 709 Rutland Avenue Baltimore, Maryland 21205	Public	Diagnosis; Evaluation	0 - 21	All

Facility	Sponsor-ship	Programs	Age Grouping	Level of Retardation
Educational and Child Guidance Clinic 233 Homeland Avenue Baltimore, Maryland ID 5-5310	Non-profit	Diagnosis; Evaluation	School age	Mild Severe
Emmorton Special School Bel Air, Maryland	Public (County)	Day care	6 - 19	Trainable
Harford County Day Care Center for Retarded Children, 205 Hayes Street Bel Air, Maryland TE 8-5644	Non-profit	Day care	3 to 21+	All
Harford County Public Schools 45 East Gordon Street Bel Air, Maryland	Public	Special education	School age	Educable; Trainable (Elementary)
Havre de Grace Special School Stokes Street Havre de Grace, Maryland	Public (County)	Day care	6 - 19	Trainable
Henryton State Hospital Henryton, Maryland 787-2400	Public (State)	Residential training	School age; Adult	Severe
Howard County Public Schools Clarksville, Maryland	Public	Special education		Educable; Trainable (Elementary)
Loyola College 4501 North Charles Street Baltimore, Maryland	Jesuit Order	Master's Degree; Special education in mental retardation		
Oakwood School Oakwood Road Glen Burnie, Md.	Public	Special education	4 - 15	All
Occupational Training Center & Sheltered Work-shop for the Retarded 4321 Old York Road Baltimore, Maryland 889-7040	Non-profit	Sheltered workshop	18+	Mild Moderate
Perryville Special School Perryville, Maryland	Public (County)	Education	6 - 18+	Trainable
Providence Center for Exceptional Children 1790 Lincoln Drive Annapolis, Maryland 268-0095, 263-9489	Non-profit	Day Care	3 to 21+	All

Facility	Sponsor-ship	Programs	Age Grouping	Retardation Level of
Rosewood State Hospital Owings Mills, Maryland HU 6-5200	Public (State)	Residential, Diagnosis, Evaluation, Day Care	All	All
Rosewood Education Dept. Rosewood State Hospital Owings Mills, Maryland HU 6-5200	Public (State)	Special education	6 to 16	Educable; Trainable
Rosewood Vocational Rehabilitation Unit Rosewood State Hospital Owings Mills, Maryland	Public (State)	Vocational training; Job develop-ment & place-ment. Follow-up services	14+	Educable; Trainable with work potential
St. Anne's Special Classes 2211 Greenmount Avenue Baltimore, Maryland SA 7-7777	Non-profit church	Education	School age	Mild
St. Bernadine's Special Education School 3814 Edmondson Avenue Baltimore, Maryland WI 7-2815	Non-profit church	Education	School age	Mild
St. Elizabeth's School for Special Education 3725 Ellerslie Avenue Baltimore, Maryland BE 5-9058	Non-profit church	Education	School age	All
St. Francis School for Special Education 2226 Maryland Avenue Baltimore, Maryland 235-3378	Non-profit church	Education	School age	Mild, Moderate, Severe
St. Gabriel's Home Hilton Avenue Catonsville, Maryland RI 7-6767	Non-profit church	Residential education	Pre-school; School age	Moderate
St. Katherine's Special School Rose and Preston Streets Baltimore, Maryland 727-7777	Non-profit church	Education	School age	Mild; Moderate
School of the Chimes, Inc. 1803 Thornbury Road Baltimore, Maryland FO 7-7007	Non-profit (Assn.)	Education	School age	Mild; Moderate

Facility	Sponsor-ship	Programs	Age Grouping	Level of Retardation
Searchlight Day Care Center Coppin State College 2500 West North Avenue Baltimore, Maryland LA 3-1111	Non-profit (Assn.)	Day care	3 to 12	Moderate; Severe Profound;
Searchlight Day Care Center Cherry Hill Community Building 2700 Spelman Road Baltimore, Maryland 355-9563	Non-profit (Assn.)	Day care	5 to 21	All
Searchlight Day Care Center 5217 Denmore Avenue Baltimore, Maryland 542-7945	Non-profit (Assn.)	Day care	7 to 21+	Moderate; Severe Profound;
Searchlight Day Care Center 4119 Kennison Avenue Baltimore, Maryland 664-6851	Non-profit	Day care	School age	Severe Profound
Searchlight Day Care Center Lexington-Poe Housing Proj. 211 North Fremont Street Baltimore, Maryland WI 5-3120	Non-profit (Assn.)	Day care	Pre-school; School age	3 to 12
Searchlight Day Care Center Patapsco Methodist Church 1700 Church Road Baltimore, Maryland 288-9741	Non-profit (Assn.)	Day care	3 to 21+	All
Searchlight Day Care Center St. Luke's Evangelical Church 7001 Harford Road Baltimore, Maryland MO 4-6851	Non-profit	Day care	3 to 21	All
Searchlight Training Center 4119 Kennison Avenue Baltimore, Maryland MO 4-6836	Non-profit	Education	School age	All
Searchlight Training Center 7910 Stansbury Road Baltimore, Maryland AT 2-2165	Non-profit (Assn.)	Education	5 to 21	Severe
Searchlight Training Center 7308 York Road Towson, Maryland VA 3-6145	Non-profit (Assn.)	Education	School Age	All

Facility	Sponsorship	Programs	Age Grouping	Level of Retardation
State Department of Education Division of Instruction Special Education 301 West Preston Street Baltimore, Maryland 837-9000, Extension 460	Public (State)	Consultation Services to all counties & Balto. City	School Age	Educable; Trainable
State Department of Education Division Vocational Rehabilitation 2100 Guilford Avenue Baltimore, Maryland 837-9000, Extension 8629	Public (State)	Vocational guidance; Training; Consultation; Physical restoration; Placement	14+	Educable; Trainable
State Department of Health Bureau of Preventive Medicine Division of Community Services for Mentally Retarded 301 West Preston Street Baltimore, Maryland 21201 837-9000, Extension 8360	Public (State)	Statewide Consultation Services	All	All
State Department of Mental Hygiene, Bureau of Community Program Services: Mental Retardation 301 West Preston Street Baltimore, Maryland 837-9000, Extension 675	Public (State)	Statewide Consultation Services	All	All
State Department of Health Bureau of Preventive Medicine Division for Crippled Children Baltimore, Maryland	Public (State)	Statewide Consultation Services	Birth to 21	All
State Department of Health Division of Public Health Nursing State Office Building Baltimore, Maryland	Public (State)	Statewide Consultation Services	All	All
Sheltered Workshop of the Baltimore League for Crippled Children 1111 East Cold Spring Lane Baltimore, Maryland	Non-profit	Vocational training; Occupational training	School age; Adults	All

Facility	Sponsor-ship	Programs	Age Grouping	Level of Retardation
Sunny Acre Spa Road Annapolis, Maryland	Public	Special education	4 to 21	Moderate; Severe
Sunny Glen First Avenue Glen Burnie, Maryland	Public	Special education	4 to 15	Moderate; Severe
Sunny Meadows Crownsville, Maryland	Public	Special education	4 to 21	Moderate; Severe
Sunnyside School Quarterfield Road Glen Burnie, Maryland	Public	Special education	4 to 15	Moderate; Severe
Millersville Training Center Millersville, Maryland	Public	Special education; Vocational development	14 to 21	Moderate; Severe
Towson Coop. Day Nursery Hampton Lane & Dulaney Valley Road, Towson, Maryland CL 4-1925	Non-profit	Day care	Pre-school; School age	Mild; Moderate
Towson State College York Road Towson, Maryland	Public (State)	Undergraduate Minor Course in Special Education for Mental Retardation		

AREA II

Brookland Child Center 8306-58th Avenue Berwyn Heights, Maryland	Non-profit	Day care	6 to 12	Educable
Cerebral Palsy Center Jessup Blair Park Georgia Avenue and Belair Road Silver Spring, Maryland JU 8-4075	Non-profit	Education	Pre-school; School age	Mild
Christ Church Center 8011 Old Georgetown Road Bethesda, Maryland	Non-profit	Education	5-10	Mild; Moderate; Severe
Consultation and Guidance Center 1106 Spring Street Silver Spring, Maryland 20014	Non-profit	Diagnostic	3+	All

Facility	Sponsorship	Programs	Age Grouping	Level of Retardation
Health Department Services for Retarded and Handicapped Children Prince George's County Health Department Cheverly, Maryland SP 3-1400	Public (County)	Diagnosis; Evaluation	All	All
Hope Day Care Center 6100 South Gate Drive Temple Hills, Maryland	Non-profit	Day care	3 to 16	Mild; Moderate; Severe
M.A.R.C. Day Center 5033 Wilson Lane Bethesda, Maryland	Non-profit (Assn.)	Education	14-25	Mild; Moderate
Melwood Agricultural Training Center Dower House Road Upper Marlboro, Maryland 599-6266	Non-profit	Occupational training	School age; Adult	Mild; Moderate; Severe
Montgomery County MARC Day Care Center 11212 Norris Drive Silver Spring, Maryland 949-1454	Non-profit (Assn.)	Day care	13 to 24+	Mild; Moderate; Severe
Montgomery County MARC Nursery School for Retarded Children 9601 Cedar Lane Bethesda, Maryland WH 2-3800	Non-profit (Assn.)	Education	Pre-school; School age	Mild; Moderate; Severe
Montgomery County Public Schools 850 N. Washington Street Rockville, Maryland	Public	Special education	School age	Educable; Trainable (Elementary)
Montgomery County Sheltered Workshop 818 Silver Spring Avenue Silver Spring, Maryland 20910	Non-profit	Sheltered workshop; Occupational training	16+	Mild; Moderate
Occupational Training Center & Workshop of Prince George's County Association for Retarded Children, Inc. 4501 Hamilton Street Hyattsville, Maryland UN 4-1600	Non-profit (Assn.)	Sheltered workshop Occupational training	16+	Mild; Moderate
Prince George's County Public Schools Upper Marlboro, Maryland	Public	Special education	School age	Educable; Trainable (Elementary)

Facility	Sponsor-ship	Programs	Age Grouping	Level of Retardation
Prince George's County Retarded Day Care Center, Inc. 78th and Garrison Road West Lanham Hills Hyattsville, Maryland 772-1666	Non-profit	Day care	3 to 21	All
School of Hope 7212 Gateway Boulevard District Heights, Maryland	Non-profit	Day care	3 to 12	Trainable
School of Hope for Exceptional Children Route 1 Clinton, Maryland	Non-profit	Day care	4 to 14	Severe; Trainable
St. Christopher Episcopal Church 8001 Annapolis Road Lanham, Maryland	Non-profit	Day care	21+	Trainable
St. Maurice Day School 10000 Kentsdale Drive Potomac, Maryland AX 9-9423	Non-profit church	Education	School age	Mild
University of Maryland College of Education Special Education Program College Park, Maryland	Public (State)	Master's (Mental Retardation) Doctorate; (Special Education)*		

* Concentration in Mental Retardation, Spring, 1966.

AREA III

Allegany County Public Schools 108 Washington Street Cumberland, Maryland	Public	Special education	School age	Educable; Trainable (Elementary)
Diagnostic and Advisory Services for Handicapped Children, State Health Department (Mobile Clinic) Allegany County Health Department Union Street Building 111 Union Street Cumberland, Maryland	Public (State)	Diagnosis; Evaluation	Pre-school; School age	Mild; Moderate; Severe

Facility	Sponsor-ship	Programs	Age Grouping	Level of Retardation
Diagnostic and Advisory Services for Handicapped Children, State Health Department (Mobile Clinic) Frederick County Health Department 12 East Church Street Frederick, Maryland	Public (State)	Diagnosis; Evaluation	Pre-school; School age	Mild
Diagnostic and Advisory Services for Handicapped Children, State Health Department (Mobile Clinic) Garrett County Health Department Memorial Hospital Oakland, Maryland	Public (State)	Diagnosis; Evaluation	School age	Mild; Moderate; Severe
Frederick County Public Schools 115 East Church Street Frederick, Maryland	Public	Special education	School age	Educable; Trainable (Elementary)
Garrett County Public Schools 40 South Fourth Street P. O. Box 73 Oakland, Maryland	Public	Special education	School age	Educable Trainable (Elementary)
Green Street School Oakland, Maryland	Non-profit	Day care	8 to 21	Trainable
Hagerstown Goodwill Industries, Inc. 223 North Prospect Street Hagerstown, Maryland RE 3-7330	Non-profit	Occupa-tional training	School age; Adult	Mild; Moderate
Jeanne Bussard Sheltered Workshop 101 West South Street Frederick, Maryland 663-9588	Non-profit	Sheltered workshop	School age; Adult	Mild; Moderate
The Kemp Horn Training Center, Center Road Smithsburg, Maryland RE 9-5530	Non-profit	Residen-tial	All	All
Potomac Valley Friends Aware of Mentally Retarded and Handicapped Children Inc. 739 Washington Street Cumberland, Maryland	Non-profit (Assn.)	Day care	17 to 21+	Moderate; Severe

Facility	Sponsorship	Programs	Age Grouping	Level of Retardation
Tipahato Blue Ridge Summit Maryland 241-3141	Proprietary	Residential	All	All
Washington County Public Schools Box 730 Commonwealth Avenue Hagerstown, Maryland	Public	Special education	School age	Educable; Trainable (Elementary)

AREA IV

Benedictine School for Exceptional Children, Inc. Ridgely, Maryland 634-2112	Non-profit church	Residential education	School age	Mild; Moderate
Caroline County Public Schools, Law Building Denton, Maryland	Public	Special education	School age	Educable; Trainable (Elementary)
Cecil County Day Care Center Holly Hall, P. O. Box 572 Elkton, Maryland 21921	Non-profit (State)	Day care	3 to 12	All
Cecil County Public Schools Booth Street Center Elkton, Maryland	Public	Special education	School age	Educable; Trainable (Elementary)
Diagnostic and Advisory Services for Handicapped Children, State Health Department (Mobile Clinic) Cecil County Health Dept. 201 Courthouse Building Elkton, Maryland	Public (State)	Diagnosis; Evaluation	Pre-school; School age	All
Diagnostic and Advisory Services for Handicapped Children, State Health Department (Mobile Clinic) Wicomico County Health Department Watson Memorial Building West Locust Street Salisbury, Maryland	Public (State)	Diagnosis; Evaluation	Pre-school; School age	All
Diagnostic and Advisory Services for Handicapped Children, State Health Department (Mobile Clinic) Worcester County Health Department Snow Hill, Maryland	Public (State)	Diagnosis; Evaluation	Pre-school; School age	All

Facility	Sponsor-ship	Programs	Age Grouping	Level of Retardation
Diagnostic and Advisory Services for Handicapped Children, State Health Department (Mobile Clinic) Somerset County Health Department Princess Anne, Maryland	Public (State)	Diagnosis; Evaluation	Pre-school; School age	All
Dorchester County Public Schools 403 High Street Cambridge, Maryland	Public	Special education	School age	Educable; Trainable (Elementary)
Kent County Public Schools 400 High Street Chestertown, Maryland	Public	Special education	School age	Educable; Trainable (Elementary)
Queen Anne's County Public Schools Centreville, Maryland	Public	Special education	School age	Educable; Trainable (Elementary)
Somerset County Public Schools Court House Annex Princess Anne, Maryland	Public	Special education	School age	Educable; Trainable (Elementary)
Talbot County Public Schools P. O. Box 1029 Washington Street Easton, Maryland	Public	Special education	School age	Educable; Trainable
Wicomico County Public Schools, Court House Main Street Salisbury, Maryland PI 9-6817	Non-profit	Day care Education	7 to 16	Severe
Worcester County Public Schools, County Service Building, Market Street Snow Hill, Maryland	Public	Special education	School age	Educable; Trainable (Elementary)

AREA V

Calvert County Public Schools, Dares Beach Road Prince Frederick, Maryland	Public	Special education	School age	Educable; Trainable (Elementary)
Charles County Public Schools, The Health & Education Building LaPlata, Maryland	Public	Special education	School age	Educable; Trainable

Facility	Sponsor-ship	Programs	Age Grouping	Level of Retardation
MARC Day Care Center Shelton Building Box 222 LaPlata, Maryland 934-4561	Non-profit (Assn.)	Day care	5 to 21+	Mild; Moderate; Severe
St. Mary's Association for Retarded Children Day Care Center St. Peter's Episcopal Hall Leonardtown, Maryland	Non-profit church	Day care	All	All
St. Mary's County Group Day Care Center, Inc. Patuxent Heights 6 Lincoln Drive Lexington Park, Maryland 862-3461	Non-profit (Assn.)	Day care	5 to 12	All
St. Mary's County Public Schools Leonardtown, Maryland	Public	Special education	School age	Educable; Trainable (Elementary)